Complete Summary

GUIDELINE TITLE

Tobacco use prevention and cessation for adults and mature adolescents.

BIBLIOGRAPHIC SOURCE(S)

Institute for Clinical Systems Improvement (ICSI). Tobacco use prevention and cessation for adults and mature adolescents. Bloomington (MN): Institute for Clinical Systems Improvement (ICSI); 2003 Jul. 36 p. [54 references]

COMPLETE SUMMARY CONTENT

SCOPE
METHODOLOGY - including Rating Scheme and Cost Analysis
RECOMMENDATIONS
EVIDENCE SUPPORTING THE RECOMMENDATIONS
BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS
CONTRAINDICATIONS
QUALIFYING STATEMENTS
IMPLEMENTATION OF THE GUIDELINE
INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES
IDENTIFYING INFORMATION AND AVAILABILITY

SCOPE

DISEASE/CONDITION(S)

- Passive tobacco exposure
- Tobacco use and addiction

GUIDELINE CATEGORY

Counseling
Prevention
Treatment

CLINICAL SPECIALTY

Cardiology
Family Practice
Internal Medicine

Obstetrics and Gynecology
Pediatrics
Preventive Medicine
Psychology

INTENDED USERS

Advanced Practice Nurses
Allied Health Personnel
Health Care Providers
Health Plans
Hospitals
Nurses
Physician Assistants
Physicians
Psychologists/Non-physician Behavioral Health Clinicians

GUIDELINE OBJECTIVE(S)

- To define the appropriate interventions in the clinic setting for identification of tobacco-use status in adults and mature adolescents, and provision of counseling and assistance in tobacco-use cessation
- To improve the proportion of patients whose current use of tobacco or exposure to tobacco smoke is obvious in the chart at any primary care clinic encounter
- To improve the proportion of tobacco-users whose interest in quitting is assessed or who receive cessation advice at any clinic encounter
- To increase the likelihood that tobacco-using patients who visit the clinic will quit
- To improve the proportion of clinic-visiting tobacco users setting a quit date who received self-help materials and offers of support and follow-up on smoking cessation and/or phone counseling

TARGET POPULATION

Adults and mature adolescents

INTERVENTIONS AND PRACTICES CONSIDERED

1. Community intervention, including the establishment of smoke-free public spaces, limiting youth access to tobacco, restrictions on advertising, counter-advertising, and increasing economic disincentives to tobacco use
2. Tobacco use identification and cessation clinic program, including frequent assessment to establish tobacco use, counseling, encouragement, self-help material, non-confrontational motivational material, advice on smoking cessation, tobacco cessation consultants and classes, social support for cessation, phone line support for smoking cessation counseling, skills training/problem-solving, and follow-up after quit date
3. Pharmacotherapy, including Zyban (bupropion) and nicotine replacement therapy (nicotine gum, nicotine transdermal patches, nicotine lozenges, nicotine inhalers, and nicotine nasal spray)

MAJOR OUTCOMES CONSIDERED

- Success rates of smoking cessation interventions (pharmacotherapy, education, counseling) on smoking cessation
- Safety and adverse effects of pharmacotherapy
- Recidivism rate for tobacco users who quit

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Not stated

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Not stated

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Not applicable

METHODS USED TO ANALYZE THE EVIDENCE

Review of Published Meta-Analyses
Systematic Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not stated

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Not stated

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Not applicable

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

Clinical Validation-Pilot Testing
Comparison with Guidelines from Other Groups
Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

Institute Partners: System-Wide Review

The guideline draft, discussion, and measurement specification documents undergo thorough review. Written comments are solicited from clinical, measurement, and management experts from within the member medical groups during an eight-week period of "Critical Review."

Each of the Institute's participating medical groups determines its own process for distributing the guideline and obtaining feedback. Clinicians are asked to suggest modifications based on their understanding of the clinical literature coupled with their clinical expertise. Representatives from all departments involved in implementation and measurement review the guideline to determine its operational impact. Measurement specifications for selected measures are developed by the Institute for Clinical Systems Improvement (ICSI) in collaboration with participating medical groups following general implementation of the guideline. The specifications suggest approaches to operationalizing the measure.

Guideline Work Group: Second Draft

Following the completion of the "Critical Review" period, the guideline work group meets 1 to 2 times to review the input received. The original guideline is revised as necessary, and a written response is prepared to address each of the suggestions received from medical groups. Two members of the Preventive Services Steering Committee carefully review the Critical Review input, the work group responses, and the revised draft of the guideline. They report to the entire committee their assessment of two questions: (1) Have the concerns of the medical groups been adequately addressed? (2) Are the medical groups willing and able to implement the guideline? The committee then either approves the guideline for pilot testing as submitted or negotiates changes with the work group representative present at the meeting.

Pilot Test

Medical groups introduce the guideline at pilot sites, providing training to the clinical staff and incorporating it into the organization's scheduling, computer, and other practice systems. Evaluation and assessment occur throughout the pilot test phase, which usually lasts for three months. Comments and suggestions are solicited in the same manner as used during the "Critical Review" phase.

The guideline work group meets to review the pilot sites' experiences and makes the necessary revisions to the guideline, and the Preventive Services Steering Committee reviews the revised guideline and approves it for implementation.

Consideration was given to guidelines on smoking cessation from the following groups: U.S. Preventive Services Task Force, the Agency for Healthcare Research and Quality (formerly the Agency for Health Care Policy and Research), the United States Department of Health and Humans Services, Public Health Service, and the National Cancer Institute.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Please note: This guideline has been updated. The National Guideline Clearinghouse (NGC) is working to update this summary. The recommendations that follow are based on the previous version of the guideline.

The recommendations for tobacco use prevention and cessation for adults and mature adolescents are presented in the form of an algorithm Tobacco Use Prevention and Cessation for Adults and Mature Adolescents, with 17 components, accompanied by detailed annotations. Clinical highlights and selected annotations (numbered to correspond with the algorithm) follow.

Class of evidence (A-D, M, R, X) definitions are provided at the end of the "Major Recommendations" field.

Clinical Highlights

1. Ask about tobacco use and second-hand smoke exposure at every opportunity. (Annotations #2 and 2a)
2. Advise all tobacco users to stop. (Annotations #13 and 15)
3. Assess tobacco user's willingness to make a quit attempt. (Annotations #12 and 14)
4. Assist tobacco user's efforts to quit. (Annotations #8 and 9)
5. Arrange for follow-up. (Annotations #9 and 16)

Tobacco Use Prevention and Cessation for Adults and Mature Adolescents Algorithm Annotations

1. Community Intervention

   Tobacco use is the single most preventable cause of disease and death in our society. The Centers for Disease Control recommend that tobacco control programs be established that are comprehensive, sustainable, and accountable. The goal of a comprehensive tobacco control program is to reduce disease, disability, and death related to tobacco use by:

   - preventing the initiation of tobacco use among young people,
   - promoting cessation among young people and adults,
   - eliminating nonsmokers exposure to second hand smoke, and

- identifying and eliminating the disparities related to tobacco use and its effects among different population groups.

The components of a comprehensive tobacco control program include:

- community programs to reduce tobacco use
- chronic disease programs to reduce the burden of tobacco related diseases
- school programs
- enforcement
- statewide programs
- counter-marketing
- cessation programs
- surveillance and evaluation
- administration and management

The work group urges Institute for Clinical Systems Improvement (ICSI) medical groups, clinicians, insurance plans, and employers to actively intervene within their community to reduce tobacco use. The establishment of smoke-free public spaces, limiting youth access to tobacco, restrictions on advertising, counter-advertising, and increasing economic disincentives to tobacco use are among the most effective community actions to be supported.

2. Establish Tobacco Use for All Patients and Reassess Users at Every Clinic Visit

   Tobacco use includes all forms of tobacco: smoking cigarettes, cigars or pipes, as well as using snuff or chewing tobacco.

   Adults who have not used tobacco for at least 12 months and who have an easily visible mark on their chart to that effect should be asked about their tobacco use status yearly until abstinent for 5 years.

   Everyone without a tobacco use mark on the chart or those with a mark indicating use within the past 6 months should be asked at nearly every visit about current use and the answer documented for the provider. This frequency of use assessment should be established as a clinic policy and should be done by a staff person, preferably the one who rooms the patient.

   The two most common ways to indicate tobacco use status are with an appropriate label on the chart or with a vital sign in the progress notes.

   Adolescents should have usage reassessed at nearly every visit, regardless of whether there is a chart notation of non-use, due to their risk of beginning tobacco use at any time.

   Tobacco cessation is particularly important during pregnancy. For more information, see the related National Guideline Clearinghouse (NGC) summaries of the Institute for Clinical Systems Improvement's (ICSI's) guidelines: Preterm Birth Prevention and Routine Prenatal Care. The guideline

developers recommend that clinics have a particularly consistent identification and cessation program for pregnant women and preconception visits.

Tobacco cessation is also very important in those individuals with heart disease or other risk factors for heart disease. (See the related NGC summaries of the ICSI guidelines: Stable Coronary Artery Disease, Lipid Management in Adults, and Hypertension Diagnosis and Treatment).

Evidence supporting this recommendation is of classes: A, C, D, M, R

2a. Establish Second-Hand Smoke Exposure for All Patients and Encourage a Smoke-Free Environment

Inform patients of their increased risk of disease due to second-hand smoke exposure. Encourage a smoke-free living and working environment for patients, and assist the exposed patient to communicate with other household members about decreasing smoking in the house. Encourage the patient to support smoking cessation efforts among other household members who use tobacco.

3. Document the Tobacco Use Discussion

All discussions with tobacco-users should be documented, either in the progress note or on a special card or flow sheet if a clinic uses that approach. This documentation should include the user's attitude toward treatment and any quitting plans agreed upon. The documentation can be very brief.

5. Reinforce Non-Use

If time permits, it is helpful to compliment former tobacco-users. These former users are considered to be in the Maintenance stage once they have quit for at least 12 months.

6. When Did the Patient Last Use Tobacco?

Although the usual definition of a user is one who uses tobacco daily, it would be ideal to classify any individual using tobacco with any frequency as a user.

8. Wants Extra Help in Remaining Tobacco-Free?

A former user who is having some trouble remaining tobacco-free may want or need more help than the provider can supply in the 2 to 3 minutes available to discuss this topic. Common difficulties include weight gain, stress, withdrawal symptoms, or social/habit/psychological needs.

9. Congratulate on Quitting/Encourage In-Office or Referral Counseling

Those who have quit using tobacco within the last month (particularly within the past week) are at a very high risk for resuming use. Reinforcement and follow-up can be crucial during this period.

The first 12 months after quitting are the transition between the Action and Maintenance stages. These months (especially the first 2 weeks), when one is at the highest risk for relapse, are the most challenging. Encourage the patient to avoid temptations to use tobacco again. Smoking cessation often takes 3 to 4 attempts before long-term success is achieved.

Counseling can be done by the provider or, preferably, by other staff, and should be designed to help patients problem-solve any of the difficulties referred to in Annotation #8.

Counseling can also be achieved by referring a user to groups, a non-office counselor, or an external tobacco cessation specialist. It should be recognized, though, that most patients are unwilling to attend such groups, especially if they are separate from the clinic. However, any such referrals should not replace clinician advice and assistance.

Follow-up options include a face-to-face, telephoned, or mailed (postal or electronic) expression of support and willingness to help. The timing of follow-ups should be discussed with the patient; generally, the follow-up should come at the time when it will be most needed or wanted. Follow-ups can be expertly performed by office staff.

Regardless of the desirability of return visits, the guideline developers believe that there is neither time nor likelihood of return visits happening very frequently, so other arrangements should be made.

12. Intending to Quit in Next 6 Months?

Assessment of interest in quitting and timing of that interest should be done after the main reasons for the visit have been addressed, and should precede any advice about quitting. This allows a 1 to 3 minute tobacco discussion accommodating both the user's needs and the provider's time limits.

It is recognized that this discussion may not be possible or appropriate at each visit. The goal should be to discuss tobacco cessation at nearly every visit.

Remember that progress from one stage of readiness to quit to the next is valuable.

Evidence supporting this recommendation is of classes: C, R

13. Patients Not Intending to Quit in Next 6 Months

A user not ready to consider quitting within the next 6 months is called a precontemplator and is helped most when a provider avoids confrontation while conveying both the message that quitting is important and the desire to be helpful when the user is ready to consider quitting. A simple informational pamphlet about the problems attending tobacco use and an expression of the provider's desire to be helpful are far more productive than an attempt to scare or argue unwilling users into quitting.

14. Intending to Quit in Next Month?

    See Annotation #12, "Intending to Quit in Next 6 Months?"

15. Patient Not Intending to Quit in Next Month

    The contemplator is considering quitting within the next 1 to 6 months. Contemplators are accepting of supportive and respectful urging to quit and encouragement to start thinking about a serious plan for doing so. Persuasive written, audio, or video information about the pros and cons of quitting may be appropriate for contemplators.

    Evidence supporting this conclusion is of classes: C, R

16. Assist the Patient to Quit

    Negotiate the quit date

    The National Cancer Institute program recommends asking a tobacco-user who is ready to quit to set his/her own quit date.

    Counsel to support cessation and build abstinence skills.

    The Agency for Health Care Policy and Research Smoking Cessation Clinical Practice Guideline emphasizes that three treatment elements in particular are effective for smoking cessation intervention: nicotine replacement therapy, social support for cessation, and skills training/problem-solving. The guideline emphasizes the dose-response relationship between the intensity and duration of treatment and its effectiveness. In general, the more intense the treatment, the more effective it is in producing long-term abstinence from tobacco. These principles should be kept in mind when counseling and assisting the patient to stop using tobacco.

    Discuss pharmacotherapy

    Nicotine replacement therapy (NRT) and Zyban (bupropion) can be very helpful to selected patients. It is most effective if the patient agrees to completely stop tobacco use with the start of NRT or 1 week after starting Zyban (bupropion), and the patient agrees to participate in a follow-up program of some type. NRT includes nicotine gum, nicotine lozenges, nicotine transdermal patches, nicotine inhalers, and nicotine nasal spray.

    Nicotine nasal spray has been shown to be effective. It is, however, the most addictive of the products and is probably best reserved for patients who have failed other forms of NRT, who still desire to use a product to become completely tobacco-free.

    Bupropion (Zyban) has been found to be efficacious in smoking cessation and can be offered to patients who have no history of seizures, no history of eating disorders, or who are not taking any other form of bupropion (i.e., Wellbutrin) or monoamine oxidase (MAO) inhibitors.

Suggestions on the clinical use of specific pharmacotherapeutic agents can be found in the appendices of the original guideline document: nicotine patches in Annotation Appendix A; nicotine gum in Annotation Appendix B; nicotine lozenges in Annotation Appendix C; bupropion SR in Annotation Appendix D; nicotine inhalers in Annotation Appendix E; and nicotine nasal spray in Annotation Appendix F.

Combination therapy

Combining nicotine patches with other self-administered forms of NRT (gum, lozenge or spray) may be more effective than a single form of NRT.

If patients use NRT or Zyban, it is important for them to become completely tobacco-free. Ongoing use of tobacco predicts failure long-term. One strategy is to encourage patients to make their tobacco-free program more intense with each use of tobacco after their quit date. They can add an exercise program, call a help line, ask for a friend's help, read a pamphlet, etc.

Although both pregnancy and cardiovascular disease are described as contraindications for the use of NRT, there is evidence of safety in these conditions, and NRT is more safe than smoking.

Clinicians should encourage their patients to check with their insurance plans, as coverage is sometimes available for NRT.

Offer Phone Line

All Minnesotans have high quality free phone line smoking cessation counseling available to them. Clinicians seeing patients from several health plans are advised to refer patients to the Minnesota Partnership for Action Against Tobacco (MPAAT) Line (1-877-270-STOP) where they will be triaged to the various health plan phone counseling programs. Clinicians seeing patients from mainly one health plan are advised to check with that plan for the best phone number. Refer to the original guideline document for a list of health plan tobacco cessation phone counseling numbers.

Other resources

Consideration may also be given to making a referral to a tobacco cessation consultant or a center with programs in tobacco cessation. Other resources include local tobacco cessation classes, community support systems, and self help brochures and materials from drug companies.

Encourage follow-up

Encourage the patient to arrange for a follow-up soon after the quit date.

Evidence supporting this recommendation is of classes: A, C, D, M, R

Definitions:

Classes of Research Reports

A. Primary Reports of New Data Collection

Class A

- Randomized, controlled trial

Class B

- Cohort study

Class C

- Non-randomized trial with concurrent or historical controls
- Case-control study
- Study of sensitivity and specificity of a diagnostic test
- Population-based descriptive study

Class D

- Cross-sectional study
- Case series
- Case report

B. Reports that Synthesize or Reflect upon Collections of Primary Reports

Class M

- Meta-analysis
- Systematic review
- Decision analysis
- Cost-effectiveness analysis

Class R

- Consensus statement
- Consensus report
- Narrative review

Class X

- Medical opinion

CLINICAL ALGORITHM(S)

A detailed and annotated clinical algorithm is provided for Tobacco Use Prevention and Cessation for Adults and Mature Adolescents.

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The guideline contains an annotated bibliography and discussion of the evidence supporting each recommendation. The type of supporting evidence is classified for selected recommendations (see "Major Recommendations").

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Overall Benefits

- Appropriate interventions in the clinic setting for identification of tobacco-use status in adults and mature adolescents, and provision of counseling and assistance in tobacco-use cessation
- Increased likelihood that tobacco-using patients who visit the clinic will quit

Specific Benefits

The spontaneous quit rate will vary by patient population, but the community average is probably about 3 to 4% per year. Studies of interested physicians without a system in place to identify users, remind physicians, and to provide assistance, support, and follow-up suggest that these physicians have quit rates equivalent to this 3 to 4% rate. If a system is in place, one should expect at least a 10% quit rate, and 20% is readily attainable.

Subgroups Most Likely to Benefit:

- Tobacco cessation is particularly important for pregnant individuals and in those individuals with heart disease or other risk factors for heart disease.
- Nicotine replacement therapy (NRT) and Zyban (bupropion) are most effective in patients who agree to completely stop tobacco use with the start of nicotine replacement therapy or 1 week after starting Zyban, and who agree to participate in a follow-up program of some type.

POTENTIAL HARMS

Adverse Effects of Medication

Nicotine

- Patch. Up to 50% of patients using the nicotine patch will have a local skin reaction. Skin reactions are usually mild and self-limiting, but may worsen over the course of therapy. Local treatment with hydrocortisone cream (1%) or triamcinolone cream (0.1%) and rotating patch sites may ameliorate such local reactions. In less than 5% of patients, such reactions require the discontinuation of nicotine patch treatment. Another side effect of the nicotine patch is insomnia.

- Gum. Common side effects of nicotine chewing gum include mouth soreness, hiccups, dyspepsia, and jaw ache. These effects are generally mild and transient, and often can be alleviated by correcting the patient's chewing technique.
- Lozenge. Common side effects include mouth or throat irritation, headaches, nausea, hiccups, upset stomach, or dizziness.
- Inhaler. Local irritation in the mouth and throat was observed in 40% of patients using the nicotine inhaler. Coughing (32%) and rhinitis (23%) also were common. Severity was generally rated as mild, and the frequency of such symptoms declined with continued use.
- Nasal spray. Some 94% of users report moderate to severe nasal irritation in the first 2 days of use; 81% still reported nasal irritation after 3 weeks, although rated severity was mild to moderate. Nasal congestion and transient changes in sense of smell and taste also were reported. Nicotine nasal spray has a dependence potential intermediate between other nicotine based therapies and cigarettes. About 15 to 20% of patients report using the active spray for longer periods than recommended (6-12 months), and 5% used the spray at a higher dose than recommended.

Bupropion SR

The most common side effects reported by bupropion SR users were insomnia (35-40%) and dry mouth (10%).

Subgroups Most Likely to be Harmed:

Precautions

Nicotine Patch, Gum, Lozenge, Inhaler, and Nasal Spray

- Pregnancy. Pregnant smokers should be encouraged to quit first without pharmacologic treatment. The nicotine patch, gum, lozenge, or inhaler should be used during pregnancy only if the increased likelihood of smoking abstinence, with its potential benefits, outweighs the risk of nicotine replacement and potential concomitant smoking. Similar factors should be considered in lactating women.
- Cardiovascular diseases. Nicotine replacement therapy (NRT) should be used with caution among particular cardiovascular patient groups: those in the immediate (within 2 weeks) postmyocardial infarction period, those with serious arrhythmias, and those with serious or worsening angina pectoris.

Bupropion SR

- Pregnancy. Bupropion SR should be used during pregnancy only if the increased likelihood of smoking abstinence, with its potential benefits, outweighs the risk of bupropion SR treatment and potential concomitant smoking. Similar factors should be considered in lactating women.
- Cardiovascular diseases. Generally well tolerated; infrequent reports of hypertension.

CONTRAINDICATIONS

CONTRAINDICATIONS

Nicotine Nasal Spray. Nicotine nasal spray should not be used in persons with severe reactive airway disease.

Bupropion SR. Bupropion SR is contraindicated in individuals with a history of seizure disorder, a history of an eating disorder, who are using another form of bupropion (Wellbutrin or Wellbutrin SR), or who are using or have used a monoamine oxidase (MAO) inhibitor in the past 14 days.

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

- These clinical guidelines are designed to assist clinicians by providing an analytical framework for the evaluation and treatment of patients, and are not intended either to replace a clinician's judgment or to establish a protocol for all patients with a particular condition. A guideline will rarely establish the only approach to a problem.
- This clinical guideline should not be construed as medical advice or medical opinion related to any specific facts or circumstances. Patients are urged to consult a health care professional regarding their own situation and any specific medical questions they may have.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

Once a guideline is approved for general implementation, a medical group can choose to concentrate on the implementation of that guideline. When four or more groups choose the same guideline to implement and they wish to collaborate with others, they may form an action group.

In the action group, each medical group sets specific goals they plan to achieve in improving patient care based on the particular guideline(s). Each medical group shares its experiences and supporting measurement results within the action group. This sharing facilitates a collaborative learning environment. Action group learnings are also documented and shared with interested medical groups within the collaborative.

Currently, action groups may focus on one guideline or a set of guidelines such as hypertension, lipid treatment, and tobacco cessation.

Detailed measurement strategies are presented in the original guideline document to help close the gap between clinical practice and the guideline recommendations. Summaries of the measures are provided in the National Quality Measures Clearinghouse (NQMC).

RELATED NQMC MEASURES

- Tobacco use prevention and cessation for adults and mature adolescents: percentage of patients' charts that either show that there is no tobacco use/exposure or (if a user) that the current use was documented at the most recent clinician visit.
- Tobacco use prevention and cessation for adults and mature adolescents: percentage of patients with documented tobacco use or exposure at the latest visit who also have documentation that their cessation interest was assessed or that they received advice to quit.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Staying Healthy

IOM DOMAIN

Effectiveness
Patient-centeredness
Safety

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

Institute for Clinical Systems Improvement (ICSI). Tobacco use prevention and cessation for adults and mature adolescents. Bloomington (MN): Institute for Clinical Systems Improvement (ICSI); 2003 Jul. 36 p. [54 references]

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

1994 May (revised 2003 Jul)

GUIDELINE DEVELOPER(S)

Institute for Clinical Systems Improvement - Private Nonprofit Organization

GUIDELINE DEVELOPER COMMENT

Organizations participating in the Institute for Clinical Systems Improvement (ICSI): Affiliated Community Medical Centers, Allina Medical Clinic, Altru Health System, Aspen Medical Group, Avera Health, CentraCare, Columbia Park Medical

Group, Community-University Health Care Center, Dakota Clinic, ENT Specialty Care, Fairview Health Services, Family HealthServices Minnesota, Family Practice Medical Center, Gateway Family Health Clinic, Gillette Children's Specialty Healthcare, Grand Itasca Clinic and Hospital, HealthEast Care System, HealthPartners Central Minnesota Clinics, HealthPartners Medical Group and Clinics, Hutchinson Area Health Care, Hutchinson Medical Center, Lakeview Clinic, Mayo Clinic, Mercy Hospital and Health Care Center, MeritCare, Mille Lacs Health System, Minnesota Gastroenterology, Montevideo Clinic, North Clinic, North Memorial Care System, North Suburban Family Physicians, Northwest Family Physicians, Olmsted Medical Center, Park Nicollet Health Services, Pilot City Health Center, Quello Clinic, Ridgeview Medical Center, River Falls Medical Clinic, Saint Mary's/Duluth Clinic Health System, St. Paul Heart Clinic, Sioux Valley Hospitals and Health System, Southside Community Health Services, Stillwater Medical Group, SuperiorHealth Medical Group, University of Minnesota Physicians, Winona Clinic, Ltd., Winona Health

ICSI, 8009 34th Avenue South, Suite 1200, Bloomington, MN 55425; telephone, (952) 814-7060; fax, (952) 858-9675; e-mail: icsi.info@icsi.org; Web site: www.icsi.org.

SOURCE(S) OF FUNDING

The following Minnesota health plans provide direct financial support: Blue Cross and Blue Shield of Minnesota, HealthPartners, Medica, Metropolitan Health Plan, PreferredOne and UCare Minnesota. In-kind support is provided by the Institute for Clinical Systems Improvement's (ICSI) members.

GUIDELINE COMMITTEE

Preventive Services Steering Committee

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Work Group Members: David Klevan, MD (Work Group Leader) (HealthPartners Medical Group) (Internal Medicine); Thomas E. Kottke, MD (Mayo Clinic) (Cardiology); Donald A. Pine, MD (Park Nicollet Health Services) (Family Practice); Michael Schoenleber, MD (HealthPartners Medical Group) (Family Practice); David Rossmiller, MD (Family HealthServices Minnesota) (Family Practice); Renee Compo, RN, CNP (HealthPartners Medical Group) (Obstetrics/Gynecology Nurse Practitioner); Janice Taramelli (Methodist Hospital/Park Nicollet Institute) (Obstetrics/Gynecology Nurse Practitioner); Darla Havlicek (HealthPartners) (Obstetrics/Gynecology Nurse Practitioner); Penny Carson (Institute for Clinical Systems Improvement) (Measurement Advisor) (Implementation Advisor); Jenelle Meyer, RN (Institute for Clinical Systems Improvement) (Facilitator)

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

In the interest of full disclosure, Institute for Clinical Systems Improvement (ICSI) has adopted the policy of revealing relationships work group members have with companies that sell products or services that are relevant to this guideline topic. The reader should not assume that these financial interests will have an adverse

impact on the content of the guideline, but they are noted here to fully inform users. Readers of the guideline may assume that only work group members listed below have potential conflicts of interest to disclose.

No work group members have potential conflicts of interest to disclose.

ICSI's conflict of interest policy and procedures are available for review on ICSI's website at www.icsi.org.

GUIDELINE STATUS

Please note: This guideline has been updated. The National Guideline Clearinghouse (NGC) is working to update this summary.

GUIDELINE AVAILABILITY

Electronic copies of the updated guideline: Available from the Institute for Clinical Systems Improvement (ICSI) Web site.

Print copies: Available from ICSI, 8009 34th Avenue South, Suite 1200, Bloomington, MN 55425; telephone, (952) 814-7060; fax, (952) 858-9675; Web site: www.icsi.org; e-mail: icsi.info@icsi.org.

AVAILABILITY OF COMPANION DOCUMENTS

The following is available:

- Tobacco use prevention and cessation for adults and mature adolescents. In: ICSI pocket guidelines. April 2003 edition. Bloomington (MN): Institute for Clinical Systems Improvement, 2003 Mar. p. 34.

Print copies: Available from ICSI, 8009 34th Avenue South, Suite 1200, Bloomington, MN 55425; telephone, (952) 814-7060; fax, (952) 858-9675; Web site: www.icsi.org; e-mail: icsi.info@icsi.org.

PATIENT RESOURCES

None available

NGC STATUS

This summary was updated by ECRI on April 30, 1999. The information was verified by the guideline developer as of April 30, 1999. This summary was updated by ECRI on May 15, 2000, December 20, 2001, December 24, 2002, and most recently on March 25, 2004.

COPYRIGHT STATEMENT

Date Modified: 8/9/2004